STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G018	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAXTER HOUSE	POST OFFICE BOX 621 KEEN MOUNTAIN, VA 24624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		5/28/15

An unannounced annual Medicaid ICF/ID recertification survey was conducted 05/05/15 through 05/06/15. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. The Life Safety Code survey report will follow.

The census in this 12 certified bed facility was 9 Individuals at the time of survey. The survey sample consisted of 4 current Individual reviews (Individuals #1 through #4).

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on observation, staff interview, and clinical record review the QIDP (qualified intellectual disabilities professional) failed to ensure the nutritional management program was consistently followed for 2 of 4 Individuals. Individuals #3 and #4.

The findings included.

1. For Individual #3, the QIDP failed to ensure the Individuals goal to "Improve eating skills" was consistently implemented by the direct care staff.

Individual #3 was admitted to the facility 12/04/90. Diagnoses included but were not limited to: profound intellectual disabilities, intermittent

W 159

A staff meeting was immediately scheduled and completed on 5/11/15 which included all group home staff. During this staff meeting the impatance of following each individual's meal time plan was stressed. Signature pages were also placed with each individual's meal time plan on this date. All staff persons were informed of the signature pages and the fact they must immediately read and sign each meal time plan. In addition all staff persons are required to read and sign every meal time plan every three months. The QIDP visited the home on 5/11/15 and observed to ensure staff was implementing all

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Cindrea Rife | Facility Manager | 5/28/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 explosive disorder, insomnia, and history of constipation. Individual #3's record included the goal "Improve eating skills." The lesson plan was to be implemented "7 days per week...2 times daily. Monday-Sunday 5:00-5:30 PM-Monday-Friday 7:00-7:30 AM- Saturday-Sunday 9:00 AM-9:30 AM." The Procedure for liquids read as follows "...Pour 1" (inch) of liquid in a glass at a time to slow his rate of drinking down. Rapid swallowing of liquids places him at a high risk for aspiration..." On 05/06/15 beginning at approximately 7:00 a.m. the surveyor observed Individual #3 eating breakfast. Individual #3 was assisted with this meal by RT (residential technician) #1. Individual #3 was observed by the surveyor to pick up his coffee cup and take a large drink. RT #1 asked Individual #3 to slow down. Individual #3 was again observed by the surveyor drinking his coffee from his coffee cup without it being measured and drinking his milk from a large glass without it being measured. At no time during the breakfast meal was the staff observed measuring Individual #3's liquids. Individual #3 tolerated the liquids without difficulty. On 05/06/15 at approximately 7:30 a.m. the surveyor interviewed RT #1. RT #1 verbalized to the surveyor that she usually poured a small amount of liquids into another cup but acknowledged that she did not do so this am. The senior team leader was notified of the above on 05/06/15 at approximately 8:38 a.m. and the facility manager was notified on 05/06/15 at	W 159	meal time plans/diets correctly. The QIDP will continue to regularly monitor each individual's meal time plan/diet to ensure staff are implementing correctly. The QIDP will provide documentation to the facility manager, stating their findings after each visit. In addition, RT #1 received a written warning on 5/25/15 for failure to follow an individual's meal time plan.	5/28/15

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W 159	Continued From page 2 approximately 8:45 a.m. No further information regarding this issue was provided to the surveyor prior to the exit conference. 2. For Individual #4, the QIDP failed to ensure the Individuals diet of "finely chopped foods" was consistently followed. Individual #4 was admitted to the facility 06/11/13. Diagnoses included, but were not limited to: moderate intellectual disabilities, intermittent explosive disorder, seizure disorder, and hypothyroidism. The Individuals diet was documented on the face sheet as "finely chopped foods with thickened liquids." The face sheet had been updated 03/17/15. The 90 day renewal of orders, signed by the physician on 03/02/15, included the diet "Regular calorie, Finely chopped with thickened liquids." Individual #4's record included the goal "To maintain desired weight for height..." The lesson plan included the following steps "1. Provide regular calorie diet as tolerated...finely chopped Food diet with thickened liquids. 2. Encourage slowed eating and small bites to prevent choking. 3. Direct care staff will provide diet as ordered..." The annual nutrition assessment was completed on 07/07/14 "...current diet is Regular calorie finely chopped with thickened liquids..." Page 12 of 19 of the ISP (individual support plan) read in part "DSP (direct support professional)	W 159	A staff meeting was immediately scheduled and completed on 5/7/15. During this staff meeting, the importance of following each individual's meal plan was stressed. The hazards of not correctly following meal plans were also discussed. A staff involved in this incident received a written warning on 5/20/15. On 6/1/15 the day support Program will be implementing a new meal time checklist System. This checklist system will contain each individual's dietary needs and restrictions and require staff initials on a daily basis. The day Support will continue to closely monitor meal times to ensure meal plans are being correctly followed.	5/28/15

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W 159	Continued From page 3	W 159		5/28/15

makes sure (name omitted) food is finely chopped (due to him not having any teeth)..."

On 05/05/15 beginning at approximately 11:15 a.m. the surveyor arrived at the day support program that was attended by Individual #4.

The surveyor observed the Individual eating lunch beginning at approximately 12:30 p.m. Individual #4 was served a lunch that consisted of a sandwich that had been cut in four parts, fruit cocktail, salad, and thickened liquids. Individual #4 was observed to pick up his sandwich and was able to feed himself.

The Resident tolerated the diet without difficulty.

After this observation the surveyor reviewed the Individuals record.

On 05/05/15 at approximately 3:15 p.m. the surveyor interviewed (DSS) day support staff #1. DSS #1 was asked what the Individual had for lunch DSS staff verbalized to the surveyor that the Individual had a roast beef sandwich that had been toasted and cut into 4 pieces (quartered), fruit cocktail, and honey thick liquids.

After reviewing the ISP DSS #1 verbalized to the surveyor that the sandwich was "probably not finely chopped."

The issue with the Individuals diet was reviewed with the dietician and senior team leader on 05/05/15 at approximately 5:25 p.m.

No further information regarding Individual #4's diet was provided to the surveyor prior to the exit conference.

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W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff and day support staff failed to consistently implement the active treatment plans regarding nutrition for 2 of 4 Individuals, Individuals #3 and #4. The findings included. 1. For Individual #3, the group home staff failed to implement the Individuals goal to "Improve eating skills." Individual #3 was admitted to the facility 12/04/90. Diagnoses included but were not limited to, profound intellectual disabilities, intermittent explosive disorder, insomnia, and history of constipation. Individual #3's record included the goal "Improve eating skills." The lesson plan was to be implemented "7 days per week...2 times daily. Monday-Sunday 5:00-5:30 PM-Monday-Friday 7:00-7:30 AM- Saturday-Sunday 9:00 AM-9:30 AM." The Procedure for liquids read as follows "...Pour 1" (inch) of liquid in a glass at a time to slow his rate of drinking down. Rapid swallowing	W 249	5/28/15 The QIDP will continue to regularly monitor each individual's meal time plan/diet to ensure staff are implementing correctly.	

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W 249	Continued From page 5	W 249		5/28/15

of liquids places him at a high risk for aspiration..."

On 05/06/15 beginning at approximately 7:00 a.m. the surveyor observed Individual #3 eating breakfast. Individual #3 was assisted with this meal by RT (residential technician) #1. Individual #3 was observed by the surveyor to pick up his coffee cup and take a large drink. RT #1 asked Individual #3 to slow down. Individual #3 was again observed by the surveyor drinking his coffee from his coffee cup without it being measured and drinking his milk from a large glass without it being measured. At no time during the breakfast meal was the staff observed measuring Individual #3's liquids.

Individual #3 tolerated the liquids without difficulty.

On 05/06/15 at approximately 7:30 a.m. the surveyor interviewed RT #1. RT #1 verbalized to the surveyor that she usually poured a small amount of liquids into another cup but acknowledged that she did not do so this am.

The senior team leader was notified of the above on 05/06/15 at approximately 8:38 a.m. and the facility manager was notified on 05/06/15 at approximately 8:45 a.m.

No further information regarding this issue was provided to the surveyor prior to the exit conference.

2. For Individual #4, the day support staff failed to implement the Individuals diet of "finely chopped foods."

Individual #4 was admitted to the facility 06/11/13.

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Diagnoses included, but were not limited to, moderate intellectual disabilities, intermittent explosive disorder, seizure disorder, and hypothyroidism.

The Individuals diet was documented on the face sheet as "finely chopped foods with thickened liquids." The face sheet had been updated 03/17/15.

The 90 day renewal of orders, signed by the physician on 03/02/15, included the diet "Regular calorie, Finely chopped with thickened liquids."

Individual #4's record included the goal "To maintain desired weight for height..." The lesson plan included the following steps "1. Provide regular calorie diet as tolerated...finely chopped Food diet with thickened liquids. 2. Encourage slowed eating and small bites to prevent choking. 3. Direct care staff will provide diet as ordered..."

The annual nutrition assessment was completed on 07/07/14 "...current diet is Regular calorie finely chopped with thickened liquids..."

Page 12 of 19 of the ISP (individual support plan) read in part "DSP (direct support professional) makes sure (name omitted) food is finely chopped (due to him not having any teeth)..."

On 05/05/15 beginning at approximately 11:15 a.m. the surveyor arrived at the day support program that was attended by Individual #4.

The surveyor observed the Individual eating lunch beginning at approximately 12:30 p.m. Individual #4 was served a lunch that consisted of a sandwich that had been cut in four parts, fruit

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W 249 Continued From page 7

cocktail, salad, and thickened liquids. Individual #4 was observed to pick up his sandwich and was able to feed himself.

The Resident tolerated the diet without difficulty.

After this observation the surveyor reviewed the Individuals record.

On 05/05/15 at approximately 3:15 p.m. the surveyor interviewed (DSS) day support staff #1. DSS #1 was asked what the Individual had for lunch DSS staff verbalized to the surveyor that the Individual had a roast beef sandwich that had been toasted and cut into 4 pieces (quartered), fruit cocktail, and honey thick liquids.

After reviewing the ISP DSS #1 verbalized to the surveyor that the sandwich was "probably not finely chopped."

The issue with the Individuals diet was reviewed with the dietician and senior team leader on 05/05/15 at approximately 5:25 p.m.

No further information regarding Individual #4's diet was provided to the surveyor prior to the exit conference.

W 249

W 368 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a

W 368

The Facility Manager spoke with the physician on 5/21/15 in regards to individual #4 not receiving his multivitamin for several days, due to his delay in sending the pharmacist the prescription for the refill. He assured me this would not happen again and

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W 368	Continued From page 8 physician ordered medication was available for administration for 1 of 4 Individuals, Individual #4. The findings included. The physician ordered medication multivitamin was not available for administration at the facility 05/01-05/05/15. Individual #4 was admitted to the facility 06/11/13. Diagnoses included, but were not limited to, moderate intellectual disabilities, intermittent explosive disorder, seizure disorder, and hypothyroidism. Individual #4's 90 day renewal of orders dated and signed by the physician on 03/02/15 included the order "Multivitamin 1 (po) by mouth 1 X daily-Dietary Supplement." The original issue date for the multivitamin was documented as 06/11/13. When reviewing May 2015 MAR's (medication administration records) it was noted that the facility staff had placed part of a yellow post it note across the administration blocks for the multivitamin and had transcribed on this post it note "Don't Have yet." RT (residential tech) #3 was interviewed on 05/05/15 at approximately 4:40 p.m. regarding the multivitamin for Individual #4. RT #3 verbalized to the surveyor that the multivitamin had to be ordered from the pharmacy and they hadn't received it yet. The senior TL (team leader) was notified on 05/05/15 that the multivitamin was not available for administration at the facility.	W 368	that prescriptions for refill of medications would be sent in a timely manner in the future. The facility manager will continue to monitor this situation on a monthly basis, to ensure all refills are received in a timely manner.	5/28/15

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W 368	Continued From page 9	W 368		5/28/15

On 05/05/15 at approximately 5:50 p.m. the pharmacy was contacted by the facility. Pharmacist #1 spoke with the surveyor via phone. The pharmacist verbalized to the surveyor that he was unable to fill the multivitamin as he didn't have a prescription to refill the medication. Pharmacist #1 stated that he had received a prescription for the multivitamin today and would be filling it. Pharmacist #1 stated that it was sometimes difficult to get refills from the current physician.

A review of the MAR on 05/06/15 indicated that the facility staff had removed the yellow post it note and had transcribed on the MAR "Added 31 tablets on 5-5-15." The facility staff had documented on the MAR that they had administered the multivitamin at 8:00 a.m. on 05/06/15.

No further information regarding this issue was provided to the surveyor prior to the exit conference.